



COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF HEALTH PROFESSIONS LICENSURE  
**BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS**  
239 CAUSEWAY STREET, SUITE 500  
BOSTON, MA 02114  
800-414-0168  
617-973-0806

[www.mass.gov/dph/boards/pa](http://www.mass.gov/dph/boards/pa)

**PHYSICIAN ASSISTANT LICENSE APPLICATION  
INSTRUCTIONS AND CHECKLIST**

**Please read these instructions carefully. All supporting materials must be submitted to complete an application. Applications will not be reviewed by the Board until all documentation has been received.**

**General Information About the Application Process:**

**The Board of Registration of Physician Assistants ("Board") highly recommends that you refrain from accepting a Physician Assistant position in Massachusetts until you are licensed.**

Once an application is received by the Board, it takes a **minimum of 3- 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. **Incomplete applications will be returned to applicant.**

**Complete applications must include the following documents:**

- ☐ Completed application form, signed and dated by the applicant and notarized.
- ☐ 2x2 passport style color photo; white or off-white background; copies and printer generated photos are not acceptable.
- ☐ Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.

☐ Check or money order payable to the Commonwealth of Massachusetts for \$225.00; cash or foreign currency is not accepted.

**NOTE:** If you hold a Temporary Practice Certificate, you must pay this fee in addition to the fee previously paid for your Temporary Practice Certificate.

☐ Official transcripts in signed, sealed envelopes from physician assistant programs/degrees with proof of a bachelor's degree or higher. When requesting official transcripts, please inform each school's registrar that the transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.

**NOTE:** If transcripts have been previously submitted with an application for a Temporary Practice Certificate, they do not need to be resubmitted, if they were submitted within the past 12 months.

☐ NCCPA documentation of certification is required. This must be sent directly from NCCPA. On-line verification is acceptable.

☐ Verification of licensure status, in signed, sealed envelopes, or via on-line primary source verification from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdictions.

For Massachusetts licenses only, the Board also accepts printed, self-queries of online verification of licensure from the following: Board of Registration in Dentistry, Board of Registration in Nursing, Board of Registration in Pharmacy, Board of Certification of Community Health Workers, Board of Registration of Genetic Counselors, Board of Registration in Naturopathy, Board of Registration of Nursing Home Administrators, Board of Registration of Perfusionists, Board of Registration of Respiratory Care, Nurses Aid Registration Board and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification. Any printed, self-queries of online verification of licensure must be submitted with the application packet.

☐ Completed MassHealth Attestation form.

**NOTE:** If verifications have been previously submitted with an application for a temporary practice certificate, they do not need to be resubmitted if they were issued within the past 12 months.

☐ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for physician assistant licensure are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

☐ Application must be submitted on single-sided paper.

☐ Retain a copy of the completed application for licensure for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

□ All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.

\*A Supervising Physician and Work Setting Information form must be on file with the Board within thirty (30) days of beginning employment. Your license may be issued without these forms, though they have been included for your convenience.

**NOTE A:** If there has been no change in supervising physician[s] and/or work setting[s] since a Temporary Practice Certificate was issued, new forms do not need to be resubmitted.

**NOTE B:** Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

#### **IMPORTANT INFORMATION:**

Pursuant to 263 CMR 3.03 (4), Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/ registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Failure to update your address may result in failure to receive a license renewal application and expiration of your license. The address of record is where the Board mails your license and any correspondence.

The address printed on your license is a **PUBLIC RECORD** that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done online at the board's website [www.mass.gov/dph/boards/pa](http://www.mass.gov/dph/boards/pa) or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 617-973-0806.



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**COMPLETE ALL QUESTIONS**  
**License Application Fee - \$225.00**

1. Applicant Name: \_\_\_\_\_  
Last First Middle  
a. Maiden Name/Other Name (if applicable): \_\_\_\_\_  
Last First Middle
2. Temporary Practice Certificate Number (if applicable): \_\_\_\_\_
3. Address of Record: \_\_\_\_\_  
No. Street Apt. #  
City/Town State Zip Code
4. Most Recent Previous Address: \_\_\_\_\_  
(Different than Address of Record No. Street Apt. #  
- MUST BE FILLED IN)  
City/Town State Zip Code
5. Telephone Number(s) Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

6. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)  
HEIGHT: \_\_\_\_\_ Feet \_\_\_\_\_ Inches EYE COLOR: \_\_\_\_\_  
Sex: M F (Circle One) MOTHER'S MAIDEN NAME: \_\_\_\_\_  
Email: \_\_\_\_\_

7. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Pursuant to G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s. 16).

**FOR BOARD USE ONLY**

Application Number: \_\_\_\_\_ Receipt Number: \_\_\_\_\_  
License Number PA Temporary Practice Number: PAT \_\_\_\_\_

## EDUCATION

8. NCCPA Certificate Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*Applicant must arrange for official written documentation of certification to be sent directly by the NCCPA.*

9. PA Program Name/Location: \_\_\_\_\_

Degree awarded: \_\_\_\_\_ Date of Graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

*Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board. Note: If transcripts were previously submitted with an application for a temporary practice certificate, they do not need to be sent a second time.*

## VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

10. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Applicants must arrange for official documentation of current license status from each state or jurisdiction to be sent directly to the Board in a signed, sealed envelope or via on-line primary source verification.***

***For Massachusetts licenses only, the Board also accepts printed, self-queries of online verification of licensure from the following: Board of Registration in Dentistry, Board of Registration in Nursing, Board of Registration in Pharmacy, Board of Certification of Community Health Workers, Board of Registration of Genetic Counselors, Board of Registration in Naturopathy, Board of Registration of Nursing Home Administrators, Board of Registration of Perfusionists, Board of Registration of Respiratory Care, Nurses Aid Registration Board and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification. Any printed, self-queries of online verification of licensure must be submitted with the application packet***

## QUESTIONS

**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.**

11. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

12. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

13. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes ☐ No ☐

16. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

## RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

## AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed Physician Assistant in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a Physician Assistant shall be deemed no longer valid if requirements for full licensure as a Physician Assistant are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Physician Assistants to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**Attach a recent  
passport  
photo  
(2x2)**

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES: \_\_\_\_\_

[Notary Seal]

### ATTESTATION PAGE

#### Mandatory Registration(s):

☐ I am aware and have submitted a thoroughly completed application to be a fully participating provider or non-billing provider and a signed provider contract to MassHealth on \_\_\_\_\_, \_\_\_\_\_ pursuant to M.G.L. c. 112, s. 9(f)

☐ I consent to the Bureau of Health Professions Licensure and the Massachusetts Executive Office of Health and Human Services, and its enrollment vendor, to obtain, read, copy and share with each other information regarding my MassHealth application and enrollment status and professional licensure status.

<http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html>

☐ I am aware that if I am or become a licensed prescriber, pursuant to M.G.L. c. 94C §24(a), I must utilize MassPAT each time I prescribe a Schedule II-III opioid and when prescribing a benzodiazepine or DPH Schedule IV-VI for the first time.

☐ Once I have obtained my Physician Assistant License and registered for MassPat, I consent to the Bureau of Health Professions Licensure and the Massachusetts Prescription Monitoring Program to obtain, read, copy and share with each other information regarding my MassPAT enrollment status and professional licensure status

<https://www.mass.gov/service-details/masspat-use-requirements>

#### Mandatory Training(s):

☐ I am aware and have completed mandatory training for all **prescribers** on Pain Management pursuant to M.G.L. c. 94C §18(e). I completed the training and received a certificate of completion on: \_\_\_\_\_, \_\_\_\_\_. [Note: it is the responsibility of licensees to retain copies of certificates to be provided to the Board upon request at any time].

Course Name: \_\_\_\_\_

<https://www.mass.gov/how-to/renew-your-physician-assistant-license>

☐ I am aware and have completed mandatory training on domestic and sexual violence pursuant to M.G.L.c. 112 §264. I completed the training and received a certificate of completion on \_\_\_\_\_, \_\_\_\_\_.

Course Name: \_\_\_\_\_

<https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives>

☐ I have completed a one-time course of training and education in the diagnosis, treatment and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia.

Yes ☐ No ☐

Course Name: \_\_\_\_\_

If you have not completed this one-time course, you must complete the course to satisfy initial licensure/ license renewal requirements. For a list of available trainings, please see pages 20-21 at the following link:

<http://patientcarelink.org/wp-content/uploads/2018/11/18-11-19ALZandDementiaFINAL.pdf>.

☐ I hereby certify that the information herein is true to the best of my knowledge.  
Signed under the pains and penalties of perjury:

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Replacing supervising physician:**

Previous Supervising Physician: \_\_\_\_\_  
Last First MI License #

Termination Date: \_\_\_\_\_

New Supervising Physician : \_\_\_\_\_

Facility Name : \_\_\_\_\_

Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Adding additional supervising physician:**

New Supervising Physician: \_\_\_\_\_  
Last First MI License #

Facility Name : \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Terminating a supervising physician:**

Physician Name: \_\_\_\_\_  
Last First MI License #

Termination Date: \_\_\_\_\_

**Clinical setting :** Please check all areas of practice that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Administration     | <input type="checkbox"/> General Surgery        |
| <input type="checkbox"/> Adolescents        | <input type="checkbox"/> Occupational Health    |
| <input type="checkbox"/> Clinical Research  | <input type="checkbox"/> Pediatrics             |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Primary Care           |
| <input type="checkbox"/> Education          | <input type="checkbox"/> Obstetrics/Gynecology  |
| <input type="checkbox"/> Internal Medicine  | <input type="checkbox"/> Other (Please Specify) |
| <input type="checkbox"/> General Medicine   | _____   |

### **Section III : To be filled out by Supervising Physician**

**If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.**

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

**A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at [www.massmedboard.org](http://www.massmedboard.org). Send the profile and the completed form to the MA Board of Physician Assistants at the address above. Make a copy for your records. You will not receive confirmation of receipt by the board.**

